Health Savings Account (HSA)
Payroll Contribution Form

Return to:
HUMAN RESOURCES
WITTENBERG UNIVERSITY
P.O. BOX 720
SPRINGFIELD, OH 45501

Please check: ☐ Bi-weekly payroll ***OR*** ☐ Monthly payroll
Please sign, date, and complete each line on the enrollment form.
Please enter zero (0) where no amount is being deducted.
Return the completed and signed form to the HR Dept.
For enrollment assistance, call 937-327-7519.

Participant Last Name _____ First Name _____ Middle Initial _____

Participant Email Address _____ Participant Phone Number _____

Participant Address _____

City _____ State _____ Zip _____

Participant's Plan Effective Date _____

2023 Contribution Amount

Your contribution amount will be divided over 12 pays or 26 pays per your payroll status (monthly or bi-weekly). The 2023 contribution amount cannot exceed the IRS limit of $3,850 for employee only coverage and $7,750 for all other coverage levels. Employees age 55 or over may contribution an additional $1,000 HSA catch-up contribution above the IRS limits. The employer contribution ($650 for single coverage level and $1,300 for all other coverage levels) ***does*** count toward the IRS limit; so your employee contribution + the employer contribution cannot exceed the IRS contribution limit.

I request the following amount to be deducted pre-tax:	**IRS Contribution Limit** **(includes Employee + Employer contributions)**	**Employee *Per Pay* Contribution Election**	**Employee *Annual* Contribution Election** **(multiply per pay contribution by 12 if paid on the monthly pay schedule or by 26 if paid on the bi-weekly payroll status)**
HSA Medical Single Coverage	$3,850		
HSA Medical Family Coverage	$7,750		
HSA Catch-Up Contribution (age 55)	$1,000		

- **All *new* HSA enrollees: The HSA Custodial Agreement and the HSA Electronic Disclosure form must also be printed, signed, & returned to HR along with this enrollment form.**
- **Medicare eligible employees: The HSA & Medicare Status form must be printed, signed & returned to HR with this enrollment form.**

AUTHORIZATION: I certify the above information to be true to the best of my knowledge. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand my share of eligible group premium(s) will be automatically deducted before taxes.

Authorized Signature _____ Date: _____